OBSERVATIONS ON THE PARTICIPATION OF NURSES AND PHYSICIANS IN CHRONIC CARE*

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IT was not too long after the Medicare program became operative that Congress and the administration became concerned about the extent to which costs of the program were exceeding prior estimates. As a consequence, a section was included in the 1967 amendments to the Social Security Act authorizing various incentive reimbursement experiments to see if ways could be found to achieve financial savings or at least to slow the rate of increase in costs.

A substantial number of inquiries and research proposals were submitted to the Social Security Administration. Indicative of the difficulty of coming up with possible solutions to the cost problem in the delivery of health services, however, is the fact that only three studies were finally funded. One of these is being conducted by the Health Insurance Plan of Greater New York (HIP).

The HIP Incentive Reimbursement Experiment (IRE) is qualitatively different from the other two and is more complex. Conceptually, the HIP experiment focuses on the patient moving through a system of health services to see whether this can result in a significant

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reduction in the total number of hospital days as compared with the situation among Medicare beneficiaries not in the program.* The experiment has two major components.

First, it is believed that, through a program of more intensive health maintenance activity for selected Medicare patients whose conditions are such that they are high risks for hospitalization and who are high utilizers of services, there could be a reduction in the incidence with which certain of these patients might be hospitalized. For example, it is thought that a substantial number of patients with heart disease might be prevented from going into congestive heart failure through more intensive ambulatory programmatic activity and the monitoring of their condition. The same concept would apply to diabetes and other conditions.

Second, it is thought that through a more intensive program of early-discharge planning that the length of stay for those patients who are hospitalized might be appreciably shortened by the timely discharge of such patients when medically appropriate. Thus the program focuses on working with the patients in an ambulatory setting to prevent hospitalizations, following the patients into the hospital when they do become hospitalized, working toward their early discharge, and following these patients once again at the group center upon their discharge from the hospital. If a patient is to be discharged to an extended care facility, the same generic activities would be performed as in the hospital, that is to say, coordinating the planning for as early a discharge as would be appropriate and resuming activity with the patient in the center. In other words, the design of the study calls for continuous following of the patients. The goal is to reduce the total number of hospitalized days and, to a lesser extent, other institutional stays, as the means for reducing costs. If such an experiment proves successful, there could well be substantial savings to the Social Security Administration since the cost for hospital care in New York is about $100 a day.

Except for this experiment, HIP has not heretofore been directly involved with the Part A Medicare costs (those for hospital benefits). It has been concerned only with the Part B benefits. However, for this experiment HIP will be concerned with the total cost for the entire

*For a more complete description of the study see: Sam Shapiro: Incentive Reimbursement Experiment at the Health Insurance Plan of Greater New York, *Proc. 19th Annual Group Health Institute* (Washington, D.C., Group Health Association of America, 1969), pp. 101-06.

range of medical, institutional, and home-care services covered by Medicare. It is doing this, however, without altering the existing Medicare reimbursement procedures.

It should be noted that the groups affiliated with HIP are private partnerships (or corporations) of physicians who have a contractual relation to provide medical care services to those enrolled in HIP. For the experiment, six HIP groups were selected and agreed to participate in the experiment. The reason for limiting selection to only six groups was primarily in terms of considerations of cost. The criteria for group selection were that the group have a substantial number of Medicare enrollees, that the enrollees receive their family-doctor care in the group center rather than in doctors' offices outside the center, and that the group place a substantial portion of its Medicare patients primarily in one hospital to facilitate the programmatic activities of the experiment. The six groups best fitting these criteria were then invited to participate in the experiment. In each case the program and its objectives were explained to the partners and they then elected to participate in this study.

Our study has now been underway for about two years. To implement the study, highly qualified nurses were selected as the key professional personnel. These nurses have been termed "nurse-clinician-coordinators" (NCC) and one such nurse has been assigned to each of the six medical groups participating in the experiment. These groups care for about one third of the HIP Medicare enrollees and account for approximately the same proportion of hospitalizations. The NCC works at the medical group center with those family physicians who have large numbers of Medicare patients and who have agreed to participate in this activity.

As indicated, the primary focus of the experiment is aimed at reducing the total number of expensive hospital days utilized. A derivative goal is to study the extent to which a highly qualified nurse could play a significant role with physicians in primary care for older adults with stabilized chronic disease conditions. In connection with this, our nurse clinicians participate actively in the development of information that is directed to operational feedback purposes and toward our analysis of the process of the development of their roles and their care of patients. These data include check-list reports of ambulatory visit activities, nursing evaluations, and demographic information on the pa-

tients with whom they have worked both in the hospitals and in the centers.

While HIP is responsible for carrying out the experiment, Harvard University's Center for Community Health and Medical Care has primary responsibility for the evaluation of this project. Cost and utilization comparisons will be made between HIP enrollees and a suitable sample of non-HIP Medicare beneficiaries in the New York area covering the total range of covered Medicare benefits. This comparison will involve all the Medicare enrollees in HIP—not only those in the groups in which we have NCCs. The other groups have been informed about the program, and have been urged to work toward the same primary goals of the experiment on their own. They, too, along with the participating groups and hospitals, will share on a formula basis in any incentive payments that might be forthcoming. The inclusion in the over-all experimental design of those HIP groups in which no special concentration activities take place provides another dimension to the experiment by permitting an assessment of relative differences between the two types of groups; thus there is actually "an experiment within an experiment."

We do not as yet have hard data on either the primary or secondary aspects of our study. Preliminary data from the one hospital in which we have the greatest number of our patients, HIP's own LaGuardia Hospital, does indicate some reduction in length of stay for 1970, but we also know that this is a general phenomenon for Medicare enrollees and we do not know whether the magnitude of the changes differs from the experience outside the experimental framework.

Moreover, we have encountered problems in both the primary and secondary aspects of our study. With regard to planning early discharges from the hospital, we had anticipated that our activities would accelerate the discharge of patients requiring placement in extended-care facilities. However, shortly after the beginning of our experiment, the Social Security Administration tightened up on the definition of the criteria for eligibility for placement in nursing homes to a marked degree. The result of this is that, although we may have won the race to the door of the hospital, we fear that we are not significantly ahead in actually expediting the discharge from the hospital for those patients going to a nursing home. As indicated, this involves a problem with regard to eligibility, so that nursing homes are very cautious in accept-

ing a Medicare patient when they run the risk of having payment for that stay later denied by Medicare. Also, in the New York City area there is the complicating factor that nursing homes generally receive substantially more money for Medicaid patients than for Medicare patients. Hence, the Medicare patient is less willingly accepted. I shall not dwell on these programmatic problems. However, I thought you would be interested in knowing about at least one of the problems that can develop in an operations-research program of this nature.

Turning to the role of the nurse clinician in our program, let me first state that each of the nurse clinicians was selected on the basis of a combination of education and experience which we believed would qualify her for maximum effectiveness in all aspects of our research design. Educationally, each has at least a bachelor's degree in nursing and, in addition, has had appropriate experience in the care of patients with chronic disease, in public health nursing, in rehabilitative nursing, or a combination of such qualifications.

The secondary aspect of our study is concerned with seeing the extent to which these highly qualified nurses, in meeting the primary functions of the experiment, would play a significant role in the provision of care on an ambulatory basis. Again, there have been certain structural barriers impeding the assessment of this potential. First, the focus of the experiment has required a substantial amount of time for the nurses to be involved in planning discharges and related activities in the hospital. Second, we have been limited in the patients with whom our NCCs can work to those who are already on Medicare. Each of these factors would attenuate to some extent the degree to which our nurse clinicians could maximize the development of a role in the sharing of responsibilities for care with the participating family physicians. It is also important to note that our study is being conducted with physicians in private practice, with patients who have selected these particular doctors to provide their care and where, in many cases, there is a long-standing relation between the physicians and the patients. This is in contrast to the traditional clinic projects where the physicians often are members of a house staff without a long-range commitment to the patients and where the patients have learned to accept whatever care is offered. Thus we had anticipated that the development of an extended role for our nurse clinicians would not be easy, but we hoped that the transition to a broad role for the NCC would be fairly rapid.

To a considerable extent thus far, however, the activities of our nurses have been largely supplemental to those of the family physicians with whom they are working. These supplemental activities are, of course, valuable and have been appreciated by the physicians with whom our nurses have been working. Indeed, a number of them have commented on the extent to which this has helped them in improving the over-all care of their patients and has avoided hospitalizations in a number of instances. However, the movement toward a team for the care of patients in which certain complementary roles would have evolved, rather than having a high proportion of the activities remain in the supplemental area, has been slower than was initially projected. It is clear that we were overly optimistic about the rate at which it would be possible to develop, with a relatively large number of physicians, a closely integrated approach that involved the NCC in the interchange of professional perspectives on how best to care for the patients in the study and that would result in the management by nurse clinicians, with the concurrence of the family physicians, of a portion of the visits that are usually made to the family physicians.

You will recall that about two years ago the American Medical Association (AMA) proposed that 100,000 nurses be utilized to deal with the shortage of physicians. You may also recall the justified response from the American Nurses Association that it was not the prerogative of one profession to speak for another. Our experience suggests that changing the patterns of practicing physicians and the relations between nurses and physicians is not the simple matter that was suggested by the AMA announcement. A major problem exists with regard to the training that physicians receive in medical school, in postgraduate training, and in the patterns and habits of practice they develop during training and subsequent to it. The physician's feeling of total responsibility for his patient and of meeting his perception of his patient's needs by himself, or by referral to another physician, is not easy to change. Indeed, some of the physicians in our study have expressed anxiety about "losing" their patients to the nurses and, in many cases, they seem unsure of the abilities of nonphysicians to share the care of patients and are very cautious about moving in such a direction.

It should be noted that, traditionally, older patients with chronic disease have not been those of greatest interest to physicians. Thus

there is a certain predisposition not to be as interested in the multiplicity of health-related factors—not necessarily purely "medical" factors—involved in the care of such patients. Conversely, our nurse clinicians are particularly expert in these *health* factors. As a consequence of this difference in perspective, some of the physicians have remarked that some of the patients are being overly cared for but without the prospect of significant improvement in their *medical* conditions.

Our nurse clinicians are faced with the obvious difficulty of establishing a role where none existed. This is not merely the task of establishing one de novo, but the more difficult one of replacing a well-established pattern. Also, the NCCs have been faced with the variable interests and expectations of the several different physicians with whom each of them has worked. The NCCs, too, have been contending with the issue of what duties and responsibilities they might best assume in sharing with the physicians the care of the IRE patients, and it is fair to state that there is not unanimity even among our six nurses on this subject.

Thus crucial factors involving a rethinking and restructuring of traditional doctor-nurse relations are at issue in deciding how to meet the needs of patients best. Traditionally, the concept of need in health services has been defined by physicians. We believe that others should help to define this need, and we suggest that two of these important "others" should be the patient himself and someone like the nurse clinician.

For the future we continue to believe that, for patients with chronic disease, care will come to be a team responsibility between a physician and a nurse clinician. Older persons are becoming proportionally a greater part of the population. Hence, the need for chronic care will also grow. Increasingly physicians do not have the time to devote to such care. In addition, their training emphasizes working with the more interesting, diagnostically challenging, and "curable" conditions. The structure of medical education is heavily oriented to the types of cases found in teaching hospitals, and little emphasis has been placed on the ambulatory management of chronic disease, nor have many physicians in training had to deal with the range of health-related problems of older adults. This could well be satisfactory, however, for the physicians' special skills are in short supply, provided that the other dimen-

sions of the management of patients are carried out by other professionals, well-trained for such responsibilities. But our observations to date indicate that the development of the medical team, both conceptually and operationally, is a slow process. Our experience has reaffirmed what others in other health care settings involved with other population groups have found: i.e., that the definition of new types of responsibilities for nonphysicians in the care of patients and the full implementation of these responsibilities are not easily accomplished even when the nonphysician personnel are highly competent and adaptable and physicians voluntarily enter into the program. We also believe that the evolution of the health care team will be significantly accelerated if both physicians and nurses share in educational and clinical experiences specifically designed to meet this objective. This is not an original observation, but it does bear repeating, for neither medical nor nursing education have, for the most part, succeeded in implementing such programs. We also hope that new insights into the circumstances that lead to full or only partial realization of the expected allocation of responsibilities in caring for the chronically ill, aged patient will result from HIP's experimental program, and that this will be useful in the developing of future educational and operational programs directed toward the better care of patients.